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The information needs and information-seeking behaviours of homecare workers and clients receiving homecare

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Abstract

Aims and objectives

Discusses findings from doctoral research on the information behaviour of homecare workers and their clients. The paper focuses on the findings, which have implications for health library and information services.

Sample and Methods

The qualitative research methods included participant observation in the homes of clients (n=7), over a period of 18 months, in a city in the UK, complemented by in-depth interviews of homecare staff (n=47).

Results

Homecare staff perceived requests for information on a variety of topics as an indivisible part of their caring role. Clients asked for more information than they had in the past, and homecare workers were expected to respond to a wide variety of enquiries about health, welfare, leisure and domestic

concerns. Clients trusted their advice as much as they might have trusted members of the family. Homecare workers from an agency used a variety of resources at the agency office to help them, such as leaflets on welfare benefits, health conditions. Few had used NHS Direct, and library use (by a third of the homecare workers) was generally associated with course work or training. Some family members and homecare staff used self-help groups, but the research found that family members were sometimes reticent to ask advice on sensitive issues in self-help groups. Homecare workers learnt from each other and shared experience.

Conclusions

Libraries and information services need to target provision of formal information carefully, as it is advice and counsel that is required in the homecare setting.

Key Messages

1. Homecare workers who work with clients over a long period of time are expected to provide information and advice to their clients on a wide range of issues. Homecare workers view this as part of their caring role.
2. Care managers and health professionals rely on homecare workers to provide information about changes in the status of clients' health or social welfare.
3. Homecare workers used a variety of information resources but tended to rely on advice from other homecare staff, and leaflets at the agency office.
4. Homecare workers made little use of formal resources such as libraries or online services such as NHS Direct, as they do not want choices, they want timely advice on what to do.
5. Library and information services supporting social care staff may be advised to target staff doing courses as staff tend to use libraries only when attending training.

Introduction

Social care is costly, 'the delivery of social care to the people of this country is a substantial task, costing £9 billion' ¹(DoH, 1998). Rationing of resources for home care is politically emotive.² Over recent years the provision of homecare has become a concern at national and local government levels. Delays in discharging older people from hospital to home or nursing homes led to the introduction in the UK of the Community Care (Delayed Discharges) Act, 2004, under which local authorities (LA) may be fined by the NHS for a patient who is bed-blocking.³ The issues are complex:

- ❑ in the latter half of the 20th century were increasing numbers of women in the formal workforce and changes in family lifestyles.
- ❑ people are living longer but may have multiple chronic conditions, to be managed in their own home
- ❑ UK community care legislation in the 1990s, allowed a switch in DSS funding (Special Transitional Grant) from residential care to domiciliary care spending⁴
- ❑ the transition of traditional home helps to homecare workers with new personal care responsibilities for clients in the early 1990s.
- ❑ a reduction in residential bed capacity⁵ in the UK
- ❑ the Care Standards Act (2000)⁵, introduces regulation of all homecare providers in the UK

Increased responsibilities of homecare workers, and rising demands and expectations of clients mean that homecare workers need more knowledge and better training to fulfil their roles. Although there is a plethora of studies on the information needs and information behaviours of health professionals little is known about these issues for homecare workers. Around 8% of the older population (UK) receive homecare (Raynes et al. 2001)⁶.

Definitions of terms used:

- ❑ 'The Agency' was a not-for-profit, independent provider of homecare, with some research functions. 'The Agency' provided homecare to private (paying) clients and to LA contract clients
- ❑ homecare workers: caregivers registered with, and paid by 'The Agency' in return for care work conducted in clients' homes
- ❑ formal and informal carers: the former are paid to carry out care work. The latter are unpaid caregivers, usually family members, friends or neighbours
- ❑ clients: people of varying dependency who received personal and / or social care in their home
- ❑ care managers: formally employed by 'The Agency' to organise and support: care provision for clients and homecare workers

- ❑ personal care: includes bathing, toileting, dressing, feeding and attending to clients' laundry
- ❑ social care: includes companionship, attending to daily needs such as shopping, collecting pension, meal provision, and finding out information to satisfy client need
- ❑ human need: may be physical, emotional or social. Need is closely linked to wants (the perception of need) and demands (expressed need).⁷
- ❑ information need is '*a recognition that your knowledge is inadequate to satisfy a goal that you have*'.⁸ Information need may be triggered by basic human need.⁹

Literature review

The existing research literature relating to the provision of domestic care is oriented towards family caregivers. Primarily, the research examines tasks and general needs.^{10 11 12 13} Olsson and Ingvad¹⁴ (2001) explored relationships and emotions between homecare workers and clients in Sweden. Henwood² saw the potential of homecare workers as information monitors. Information need as a concept is sometimes unfamiliar to people¹⁵ and not identified until the individual is prompted in some way. This may be an issue of 'problem recognition', in that the individual does not realise they have a need¹⁶. Information needs of older people are wide-ranging, but relate largely to everyday practical needs; there may be an inverse relationship between need and ability to access information.^{17 18} As age increases so social networks, physical and mental health decline. Worth¹⁹, found, as did Cawthra²⁰ that professionals are often unable to help older people with information needs: 'We know that GPs are often not well tapped into sources of information'. These problems are magnified in ethnic minority populations through cultural and linguistic differences.^{21 7}

Homecare workers seek information on behalf of their clients, clients' health conditions, or equipment being used in a homecare situation. Care managers and social care and healthcare professionals who are involved with a client look to the homecare workers in that situation for information. Professional culture, however, impedes the flow of communication, Tester and Meredith¹⁵ found that district nurses retained strict ideas about role boundaries not recognising the roles of homecare workers, who were similarly unsure of the roles of the nurses. Both formal and informal (family) carers frequently take full responsibility for a patient post discharge and despite recognition of the importance of informal carers in the Carers (Recognition and Services) Act 1995²² (UK) and the National Service Framework for Older People²³, they remain poorly furnished with information.²⁴ Research (confirmed in the current research) found that informal carers actively wanted information about the care recipient.^{25 26 27} Tester and Meredith¹⁵ concluded that 'home helps are crucial to informing the elderly', they have become the 'eyes

and ears' for their clients.²⁸ Home helps build meaningful relationships with clients over time, which helps them to synthesise and convey information to their client in a way that is understandable and acceptable.

Research by the Carers National Association between 1995-6 showed a decrease in the number of information enquiries by carers (all types) to the Welsh CNA Information and Advisory Service²⁹. There was a sharp increase in enquiries from professionals and students, particularly in legal information (carers' rights et cetera). Information sources for informal carers and homecare workers alike are generally poor and not well used; and until recently there was no national strategy to provide information for them. The UK Caring for Carers (2000) Act, 'acknowledged the need for a long term view of information needs of carers' ³⁰ and identified areas of action on information for carers. The flow of information from the care management to grass roots care delivery staff was criticised by The Audit Commission in their Joint Review³¹ of Cardiff's social service delivery in Wales. Following the Review, there may have been some changes but the limited evidence available suggests that is too early to judge how successful these have been.

Methods

This ethnographic study used participant observation and in-depth interviewing techniques to collect data. Case studies of several homecare settings were conducted over an 18-month period between summer 2001 and autumn 2002 in a city in Wales in the UK. Within the settings, clients ($n=7$) receiving care were observed only, no formal interviewing was conducted in the home. Informal conversations were possible with only four clients, linguistic differences and clients' health conditions precluded verbal communication with the three remaining clients. Interviews with homecare workers and related care professionals were conducted throughout the fieldwork (Table 1). Care work conducted prior to the fieldwork acquainted the researcher with the role of formal homecare worker and allowed identification of potential participants. The latter were made aware of the proposed research function at an early stage. One client and one care worker declined the offer to participate in the study.

Ethics were sought and approved by the Local Research Ethics Committee (LREC), and permission to conduct the research was granted by the University of Wales, Aberystwyth Department of Information Studies plus 'The Agency' to which the researcher was attached. Written consent was requested and granted by participants, or advocates. Financial assistance for the study was provided by the Arts and

Humanities Research Board, London.

Participant observation as a regular care worker was selected as a legitimate access route to otherwise closed settings. Each client was physically, emotionally and socially vulnerable and incapacitated in some way. The method was viewed as less intrusive than other techniques and a role, in which the researcher could build a relationship of trust with clients, homecare workers and other professionals over time. It was assumed that by gaining access to the homecare setting in this way, sustained observation of the delivery and receipt of care and the information flows and behaviours therein could be experienced in as natural a state as possible.³² Fieldnotes were always recorded off-site. The observation notes made it possible to verify and interpret comments made by the homecare workers in interviews, as the researcher often worked with other homecare workers during a shift. Similar claims could be made of interviews with care managers, where comments could be reinforced through telephone conversations and actions of managers. Permission was sought to observe managers within their office environment, but this was declined. There were opportunities for spontaneous and informal contact with homecare workers outside the care setting. After completion of the fieldwork, continued client care was guaranteed, as the researcher worked in team rather than solo care worker / client situations.

Professional / other role	Employer or agency affiliation (<i>n</i>)	Total <i>n</i>
Homecare workers	The Agency (22), LA (4), Other private agencies (5)	31
Social workers includes PSSO / senior social workers	Local authority (PSSO = 1), (Senior social workers =2), (Social worker =1)	4
Community health professionals	Community dentist (1), Community nurse (1), Healthcare worker (1), Day services officer (1)	4
The Agency Management staff	The Agency care managers (2), trainer (1)	3
LA managers	Local authority	2
Voluntary agency director	Crossroads Wales	1
Family members	The Agency (1) and another private agency (1)	2
Clients (<i>observed, not interviewed</i>)	The Agency (6) and another private agency (1)	7
Total number of participants		54

Table 1 Role and affiliation of interviewees

In-depth interviews (*n*=47) were conducted with consenting participants (Table 1), including two pilot

interviews and eight follow-up interviews. Interviews were audio-recorded and transcribed verbatim. An inductive approach to data coding and analysis was used, with theory emerging from the data. QSR NVIVO qualitative data analysis software was used for data analysis. Data were coded line by line, with several coding passes, and memos written to help in theory building. Samples of coded data were double-checked for coding reliability.

Although the participant observation approach provided insights hard to obtain in any other way, there are limitations to using this research approach:

- ❑ it was physically and often emotionally taxing to sustain dual roles over long days (or nights)
- ❑ 'The Agency' and clients viewed the researcher as a homecare worker, with the expectation that additional shifts could be requested
- ❑ it was necessary to build up a rapport with the other homecare workers over a period of some weeks. Most were very unused to being interviewed
- ❑ leaving clients at the end of the fieldwork was difficult due to clients' attachment to the researcher.

The fieldwork was a constant balancing act of sustaining relationships in order that clients or homecare workers would not jettison the fieldwork prematurely, yet maintaining professional distance as a researcher. Due to the small-scale nature of this study the results may not be transferable to other homecare settings and agencies, but the in-depth nature of the study provides a valuable insight into the information needs of poorly researched groups of people.

Results

Findings are presented by theme, illustrated by extracts from the raw data. The abbreviations used are:

- ❑ CW = private sector homecare worker with The Agency
- ❑ GAB = LA Domiciliary Care Services Manager
- ❑ LACW = Local Authority homecare worker
- ❑ Obs Notes=observation notes

- OPCW1 = other private sector homecare worker working for a different agency

The data in the next section come from interviews and where indicated by 'Obs notes' - from fieldnotes. Participants' roles are shown by the code following the data.

Information needs and information seeking

Clients' needs

With clients' greater personal dependency, it might be expected that homecare workers should be seeking information on behalf of their clients. All the homecare workers interviewed ($n=31$) had information needs, but in spite of the changes in homecare workers' roles and information responsibilities, some homecare workers did not perceive that role as distinct from 'caring' and required prompting to recognise that activities they carried out on a regular basis were defined behaviours. *'Um, when you say information, what do you mean?'* (CW31). CW31 had been a NHS nurse and was constantly drawing on 30 years of nursing knowledge and experience. Several others had similar backgrounds. Needing or sharing information, or finding out something were activities homecare workers engaged in, largely unconsciously, in daily life. Alongside growing physical dependency, homecare workers perceived clients' expectations and demands growing 'like Topsy', one small request for a care task leading to a much larger clinical problem requiring advice and negotiation.

'... some clients ask, 'I have got a sore toe, will you have a look at it, will you cut my toenails', and then you cut them, and or you get to cut them and one of them's you know oozing pus. And you think, hello what have we got here then, oh well it's septic isn't it, we need antibiotics so we have to ring the doctor, or get the chiropodist out, or no, 'I am not paying a chiropodist, you do it' '(CW9).

Clients wanted personal and healthcare services delivered at home and turned to homecare workers for recommendation and information about these services: *'Oh yes, we are often asked things like that, oh do you know a hairdresser?'* (CW30). Some clients perceived homecare workers as a panacea for every problem, event or need. Homecare workers stressed that clients had higher expectations of them today in terms of information provision compared to the middle to latter 1990s: *'...but a lot of 'em more, more now than, where before we used to just go in and do our job and go out, a lot of 'em want us to know information'* (LACW3).

Needs of homecare workers, health and social care professionals

Homecare workers handled non-health care problems to ensure their client's well being. OPCW1 illustrates the responsibility she assumed to help maintain her client's life at home:

'Um, I've got one lady whose... one son lives in the (place name). And he's supposed to have set up direct debits for her...and these bills are just piling through...and she can't cope with it and I've had to ring these people, gas board, electric board, you know and explain to them what's happening. I mean...hat's just one example she, she can't cope with um the paperwork' (OPCW1).

Homecare workers need information and were essential providers of information to others particularly, in the absence of family members. Health and social care professionals relied heavily on experienced homecare workers for information: *'...um because I have known him for such a long time that sometimes they'll (outside agencies) phone me with information because the family member is not always able to uh, to be contacted' (CW12).*

Rotation of junior community health professionals, plus an apparent absence of medical notes increases dependency for information on homecare workers, *'The dentist asks me if DA1 is epileptic, and I tell him that I have never known DA1 to fit, I inform him that DA1 has Down's Syndrome. He also enquires about DA1's possible response to an audible ultra-sonic scaling instrument...'* (Researcher Obs notes, DA1).

Similarly, homecare workers perceived that care managers were devolving more responsibility down to them:

'...um...I think this one leaves a lot more to us, but it's not our job. Um...basically, she just says, 'cos we can cope we, you know that's fine and we do it...I had one lady who was very distressed, threatening to commit suicide, and I phoned her and I said look, I feel as if the social worker should be informed...' (LACW3).

Care managers relied on homecare workers for information about changes in clients' health, or any other general changes which might affect the delivery of care, for example an adjustment to a care process, or change in the timing. Homecare workers sought client information from other homecare workers particularly at shift handovers: *'She asks about tomorrow, and I say that DA1 is being taken*

for a blood test by his nurse at 9:50, and will be brought back by the nurse. She asks about his specimen sample, I tell her that CW12 has left a note in the log-book for tomorrow, and left the bottle in the bathroom with a note, stating the time it should be done' (Obs notes, DA1). Most homecare workers preferred to seek client information from other homecare workers because it was perceived that in most cases they were the holders of relevant personal and accurate information.

Family needs

Increased dependence by clients and some family members on homecare workers was attributed to their just being there. As shown above by (OPCW) non-availability of family members, and reiterated here by LACW3, *'They, they're too busy in... the things they want out of life, so now and a lot of 'em say. Oh we've got the home carer now every day, we, you don't need us, we're working all day. Where before it should be additional care, whereas now we're taking the place of them I think...'* (LACW3).

In some cases, family members were available, but not did take the initiative to find information for their relative, *'the family didn't bother about phoning up for example about um inco sheets (incontinence sheets). Or about bed cot sides, um or about glide sheets all the basic things which, make um somebody's life easier'* (CW3). In one setting, a family member was frequently observed surfing the Internet for hours, on each occasion the sole purpose being to find personal leisure or work related information (Obs notes DJ1). The LA Domiciliary Care Services Manager regretted some family's responses to the changes in service provision: *'I think it's, I think it's a sad, it is a sad situation that very often where we have picked up the provision of care, it has allowed families to... abrogate that responsibility'* (GAB). This was not universal, as some family members shouldered responsibility and were active in their relative's care needs. In many care settings homecare workers themselves were viewed as family members: *'You get treated like one of the family, and they ask you what... that's what happens'* (CW30).

Information-seeking by homecare workers

Homecare workers were frequently requested to look up information for clients, or were stimulated to seek information themselves. A regular information seeking activity by homecare workers was to check the side effects of new drugs a client was taking: *'CW1 has looked out the information leaflet from the drug package and highlighted the potential side effect'* (Obs. notes DA1).

Observations in care settings verified the information needs and behaviours of homecare workers. Their responses were aggregated into several main categories: domestic services; physical health needs of a client; personal services; social needs; and family members' needs. Information-seeking is driven by someone's information need. In care settings, clients, family members, care managers, health or social care professionals, or other homecare workers generated information needs. Information needs ranged from factual information such as telephone numbers of trades' people, to intricate welfare benefits information. Homecare workers and their managers also need soft types of information to try and understand clients' demands or needs.

Often, simple information need emerged in response to a physical need, for example household utilities, *'Oh and um another lady, her plumbing had gone wonky. So I gave her the number again for the plumber'* (LACW2). In the main, homecare workers sought information through telephone directories, either personal - belonging to the client, *'Well, I am forever looking up phone numbers for HB1! In her book there, and taking phone messages because...course she can't speak over the telephone...'* (CW13), or commercial directories such as Yellow Pages. Clients receiving homecare are vulnerable people and frequently asked homecare workers for recommendations of service engineers. Homecare workers needed trusted information sources: *'Oh no, we, if we wanted an electrician well I'd find out, again if, if I didn't know through my husband 'cos with his job he...'* (CW30). Where applicable homecare workers followed up care managers' recommended routes to information: *'Well I tried to find a plumber that I knew, right...Then I phoned up the office, and they said, that to get through to um Age Concern, because they should haveUm bode fide (bona fide) is that the word?'* (CW26)

Clients wanted diverse types of information, in this instance the words of a song by a rock band *'... so she asked me if I'd do a copy for her. Um, and she was trying to remember the words but she couldn't. Uh so we actually, my daughter and I borrowed the computer, found the lyrics there, and we printed them out for her, and she thought that was wonderful'* (CW1).

In only one case did a client filter and analyse the information themselves: *'Well, he didn't actually with all of that information. Um, uh he, he was happy with having all that information because then he could work through all the information. And once he'd worked through it all he found that there were problems with each...and so he decided on something completely different...'* (CW20).

Support and self-help groups

For families and family carers, self-help groups appear to offer an immediate source of advice and support that might provide information that a homecare worker would not always be able to provide. Homecare workers did themselves use such organisations: *'...and because my children had problems and we used to have a self-help group... We talked about these things...'* (CW12). Others used self-help resources: *'And yeah, self-help books or ...'* (CW24). One instance showed a family caregiver's reticence. FH1 an elderly family member, her late sister and nephew (DA1) used to attend a MENCAP club. The researcher asked FH1 if they benefited from the club, *'Well, not a great deal, I think my sister went because it was an evening for her to mix with the mothers of these children'* (FH1). DA1's long-standing care worker claimed there was very limited advantage for the so-called 'children', *'But it was more like a mother's club by the sound of it. Um, the mothers used to go there and uh, do a bit of knitting, have a cup of tea while their 'children' played, so their 'children', you know forty, fifty year-olds um were put in another room...'* (CW12). Below CW12's comments imply that formal conventions adopted by the club members inhibited discussion around sensitive areas such as incontinence, which had been freely discussed in the self-help group she herself attended. *'...and they didn't support each other you know, she told me one day that um one of the other mothers...told her very quietly that she was having real worries because her 'child' had some incontinence problems.. They didn't, they didn't help each other with that kind of thing, you know where you can go for help, what you can use, what you can do..'* (CW12).

The weekly event was referred to by FH1 as the *'Mothers' evening'*, it was an opportunity for mothers of disabled children to talk to one other. However, these evenings reflect missed opportunities by 'the mothers' to share problems and learn from each other's responses to problems; or to seek help from other information resources such as public libraries, or patient groups. This example illustrates how clients and their families may be very dependent on the watchful interpretation of their needs by homecare workers. The homecare worker may need to act as the intermediary between the support group and the family.

Information resources

One third ($n=10$) of homecare workers interviewed were aware of, and used formal information resources available at the agency office: *'Well, they have got all the leaflets there, it, you see I would find if I was going to one...particular client, uh client and I was told that they had got MS'* (CW30). The information was wide ranging from social and health care leaflets, financial support, health conditions,

burial customs for ethnic minority members to specialist food suppliers. Homecare workers used the information for clients and their own family members, *'Yeah I have, actually I picked a couple up for my mother because there was something on um cataracts, and my mother had cataracts. And there was something...they are really useful um handouts in that room...uh blood pressure, everything...'* (CW27).

Libraries were not commonly used unless there was a specific need such as course work, and this applied more to those doing NVQ training. The findings showed that:

- ❑ eleven used libraries or other formal sources such as telephone helplines
- ❑ ten said they would use a library if the need arose
- ❑ ten said they would not use a library, due to:
 - time constraints
 - language barriers
 - preferences for face-to-face interaction. CW19 expressed this preference but also used a library
 - information needed is specific to the individual setting (CW2)

Whilst CW19, CW21 and CW24 mentioned personal time constraints they had, or would use a library to find client-related information. Similarly, few homecare workers sought information from NHS Direct, and this was linked to their own family's needs. Care managers had used NHS Direct for infectious disease information. The majority of the homecare workers had collected leaflets from 'The Agency', GPs' surgeries, post offices or hospitals. However, use of this literature was prompted by attendance at a new client with a health condition the homecare worker had not worked with before. Homecare workers also had notes from training courses, but these appeared to be little used. The dominant preference was to seek information from trusted colleagues.

Discussion

This qualitative study offers a rare insight into the ways homecare workers respond to implicit and explicit information requests from their clients, their managers and the health professionals. In the current environment of homecare, care managers expect homecare workers to assume more responsibilities relating to care tasks and information handling. Sinclair and Williams¹⁰ found clients reluctant to involve their (then) home helps in personal or private affairs. This has changed and clients now expect homecare workers to be a one-stop shop conducting domestic and personal care tasks and

finding information for them. Homecare workers are acting as information gatekeepers. Once the care package is established care managers play a secondary role in responding to information requests. Information seeking has been categorised under social care (see definition of terms on page 3) because it is a service to the client, but is not akin to personal care or domestic tasks. Client needs stimulated information needs of homecare workers, who often recognised the need before it was expressed. Paradoxically some did not recognise the processing of the problem i.e. dealing with information as an activity, it was simply an automatic response to need, reflecting findings in a study by Pettigrew³¹ of nurses dealing with 'senior' clients in community clinics in Ontario²³. Needs, and sometimes demands fell into several main categories:

- ❑ domestic services
- ❑ physical health needs of a client
- ❑ personal services
- ❑ social needs
- ❑ family members' needs

These echo other research findings.^{7 13 14 15 17 24}. Much of the information required was factual information but some was less clearly defined. The retrieved and triangulated data reveal intimate, often simple, though nonetheless important information needs. Information seeking was conducted largely using directories of various types: Yellow Pages, personal directories, or care services' related directories and care organisations such as Age Concern, few homecare workers used public libraries, NHS Direct or The Internet. In some instances, homecare workers used product information and local service agents. Information needs of clients, homecare workers or family members were often satisfied by someone's personal knowledge and experience. Homecare workers often involved their spouse to resolve the problem. Former nurses drew on their own experience and knowledge surrounding issues that related to clients' health needs. Clients trusted homecare workers to suggest reliable, trustworthy services and sources of information. This was based upon close mutual relationships forged between members in the care setting. In new and dependent care situations clients had to trust homecare workers' advice immediately. This was particularly true where family members were not easily accessible. Underlying this reliance is the possibility of abuse by homecare workers with vested interests in a particular service provider, *'I knew a good locksmith, so I recommended...'* (CW31). The local Age Concern office holds a list of reliable trustworthy trades

people, but one client's experience of using one of the listed plumbers was summed up by her homecare worker: *'he was a messy worker and extortionate!'* (CW26). As the evidence suggests protecting vulnerable clients from exploitation by unscrupulous people is beset with difficulties.

Opportunities for sharing sensitive problems and information in self-help groups were not exploited because of taboos around incontinence, and the persistent views of older family carers of their dependent adults as 'these children'. Homecare workers often used their personal time and resources to carry out information seeking, collection and synthesising of activities. A significant advantage of the care worker as information seeker and provider is their regular physical contact with their clients. This enables follow-up of an information problem, and feeding back to the client to ensure that the episode remains on the relevant course (again echoing Pettigrew's observation of feeding information as they needed it and could respond, but the time scale and the intensity of interaction are different). The homecare worker can help the client analyse the information and make decisions. Frequent attendance and familiarity with the client and their personal life makes the experienced homecare worker an obvious choice for social and healthcare professionals seeking information about the client. The success of care delivery depends on the fluid flow of information between the complete network of people involved in that process. However, their usage of formally produced information resources was constrained by preferences for face-to-face interaction with colleagues, care managers or family members. The data show that amongst the homecare workers (n=31) studied:

- ❑ nine used leaflets
- ❑ six used self-help groups including Diabetes UK (n=3), The Samaritans (n=1), Imperial Cancer (n=1), Parkinson's Society (5)
- ❑ one third used libraries

Within the closed world of homecare information needs are focused on giving advice to solve an immediate problem. For the client the need can be a domestic problem, for the homecare worker the need may focus on advice on how a client should react to particular drugs and how they might be expected to behave if suffering from a particular condition. Printed information in leaflet form often meets that need sufficiently well, and homecare workers do rely on colleagues for advice on clients' behaviour and conditions.

Self-help groups can and do provide information for homecare workers when more detailed information is required. More formal information services such as libraries are used far less frequently, and services

such as NHS Direct were only beginning to be used during the course of this study. Homecare workers' patterns of information seeking and use are very similar to those of nursing staff^{33 34} with library use associated with information needs for coursework or training. Evidence-based practice was not a concept that seemed relevant to the homecare staff, as they were responsible for watchful monitoring of clients, rather than making care decisions. Homecare workers were often unaware of the skills and experience they had, passing this off as 'common sense', and only realising how much they had learnt while caring for a client when they had to go to a new client or introduce a new homecare worker.

Health library and information services wishing to serve social care staff have no obvious formal function within the closed world of homecare itself. There are, however, opportunities for libraries to build up trust between themselves and homecare workers when homecare workers undertake training, as many of them now have to do. Other opportunities are in outreach work to care managers who have responsibility for ensuring that the information they provide to their staff is reliable, and authoritative.

Conclusion

The above data show that the homecare workers interviewed need and seek information. They are exchanging information with other homecare workers, clients, care managers and health or social care professionals. Basic needs of clients often become homecare workers' information needs. Needs are diverse, sometimes simple and are occasionally complex and demanding. Homecare workers currently use leaflets, and information acquired through care managers, Age Concern or specialist societies e.g. Diabetes UK. Maintenance of an information resource by a care agency is difficult because information loses its currency, and is often fragmented. If social care is devolved to several agencies, rather than being centralised, the problem increases. Trust is an important value for homecare workers, and health library and information services will need to build up trust with key personnel in the world of homecare to succeed. Most homecare workers interviewed were not information technology literate. In this study, few were aware of national resources available to them such as the CNA. They were more aware of resources if a member of their family had a special need.

As social care dependency increases, so do the information needs of caregivers. Policy makers' rhetoric demands better information for carers, yet in practice information provision for homecare workers is low priority, and their needs inefficiently served. The findings showed that one third of

homecare workers use libraries and several of these were motivated to do so only for course work. Of the thirteen care managers and health and social care professionals, most used work-based or voluntary libraries, a few used academic libraries. Most clients were housebound and family carers had little time to chase up information. The challenge is open to information professionals in health, LAs, and voluntary agencies to make current information more accessible to clients, and homecare workers. This could be done via outreach work directed to trainers, and homecare managers in LAs and private agencies who can then cascade information to homecare workers. Information resources need to be up-to-date, succinct, digestible, written in plain English, low cost and in a format that can be easily updated.

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